84-1157

No.

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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1984

NKC, INC. - - - - - - - - Petitioner

versus

MARGARET M. HECKLER, Secretary,
United States Department of
Health & Human Services - - - Respondent

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether the Secretary of Health & Human Services is entitled to due deference with respect to her 1977 interpretation of a 1972 regulation applied retroactively to the Petitioner?

2. Whether the Sixth Circuit erred in holding that the District Court's application of the incorrect regulation to the Petitioner's Transitional Care Unit was not reversible error?

3. Whether the decision of the Secretary of Health & Human Services denying special care unit status to the Petitioner's Transitional Care Unit for purposes of Medicare reimbursement is supported by substantial evidence?

4. Whether the Secretary of Health & Human Services abused her discretion and acted in an arbitrary and capricious manner by failing to properly weigh the determination of the administrative agency as the trier of fact?

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IN THE

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No. _____

NKC, INC. - - - - - *Petitioner*

v.

MARGARET M. HECKLER, Secretary, United States Department of Health & Human Services - - *Respondent*

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

NKC, Inc.[1] respectfully prays that a Writ of Certiorari be issued to review the judgment of the United States Court of Appeals for the Sixth Circuit entered in this proceeding on November 15, 1984.

OPINIONS BELOW

The opinion of the Court of Appeals, not yet reported, appears in the Appendix hereto. The opinion of the district court is unreported and is also reproduced in the Appendix. The decision of the Deputy Administrator, Health Care Financing Administration, and the Provider Reimbursement Review Board are unreported and appear in the Appendix.

[1]Disclosure of corporate affiliations and financial interest filed with the United States Court of Appeals for the Sixth Circuit as of November 28, 1983. Since that date, there has been a name change and NKC, Inc. is now known as NKC Hospitals, Inc.

JURISDICTION

The judgment of the Court of Appeals for the Sixth Circuit was entered on November 15, 1984. This petition for certiorari was filed within sixty (60) days of that date. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTES AND REGULATIONS INVOLVED

Medicare Act, 42 U.S.C. §§1395x(v)(1)(A) and 1395hh, 42 C.F.R. §405.452(d)(10) (1972) and 42 C.F.R. §405.452(d)(1980). The text of these provisions is set forth in the Appendix.

STATEMENT OF THE CASE

This action arises under Part A of the Health Insurance for the Aged & Disabled Act established in Title XVIII, Section 1801 *ct seq.* of the Social Security Act, 42 U.S.C. §1395 *et seq.,* as amended (the "Medicare Act"). The Medicare Act establishes a program of health insurance under which a person who qualifies as a beneficiary is entitled to have payment for hospital services made on his/her behalf by the Medicare program.

A participating hospital (i.e., a "provider" of services) receives Medicare reimbursement at least once each month for health care services rendered to program beneficiaries, usually through private insurance companies denominated "fiscal intermediaries" acting under contract with the Secretary of Health & Human Services (the "Secretary"). 42 U.S.C. §§1395g and

1395h. At the end of the twelve month cost reporting period, a provider must file a cost report with its Medicare fiscal intermediary. 42 C.F.R. §§405.406 and 453(f).

If a provider disputes its fiscal intermediary's final determination of the amount of Medicare reimbursement due during the reporting period, such as was the case with the Petitioner, NKC, Inc. (the "Provider"), it may obtain a hearing before the Provider Reimbursement Review Board (the "Board" or "PRRB") if the amount in controversy is at least $10,000. The Board, an administrative tribunal established by 42 U.S.C. §1395oo, has the power to affirm, modify, or reverse the final determination of the fiscal intermediary with respect to a provider's cost report. 42 U.S.C. §1395oo(d). The Secretary has delegated to the Administrator, Health Care Financing Administration, authority to conduct "own motion" review of decisions made by the Board. 42 *Federal Register,* 13,262 (March 9, 1977).

The Medicare Act requires that the amount of reimbursement paid to a provider for services be based either on the "reasonable cost of such services" or on its customary charges for the services rendered, whichever is less. 42 U.S.C. §1395f(b). The reasonable cost of services is defined by the Medicare Act as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. §1395x (v)(1)(A). The Secretary is authorized to promulgate regulations establishing the "method or methods"

for ascertaining what costs are unnecessary in accordance with the statutory mandate. *Id.*

The fiscal intermediary herein, Blue Cross and Blue Shield of Kentucky, Inc. ("Blue Cross") notified the Provider that various costs claimed for the cost reporting periods ending December 31, 1977 and 1978 had been disallowed. Thereafter, pursuant to the Medicare Act and its implementing regulations, the Provider filed an appeal with the Board to contest the costs disallowed by Blue Cross with respect to its special care unit, known as the Transitional Care Unit ("TCU").

The case was presented to the Board and a full evidentiary hearing conducted on April 16, 1981. On December 10, 1981 the Board issued an unanimous decision in favor of the Provider (Decision No. 82-D24). In its decision, the Board determined that the TCU in question qualified as a special care unit in accordance with the provisions set forth at 42 C.F.R. §405.452(d)(10)(1972).

By a decision bearing the date of February 4, 1982, the Deputy Administrator, Health Care Financing Administration, reversed the decision of the Board. The Provider then timely filed an action for judicial review in the United States District Court for the Western District of Kentucky. The jurisdiction of the District Court was invoked under 42 U.S.C. §1395oo(f)(1). The District Court granted the Secretary's motion for judgment on the pleadings, holding, however, that "[I]f this Court were writing on a clean slate, we would have no hesitancy in finding that plain-

tiff's TCU meets the criteria of the regulation." The lower court cited the amended regulation promulgated in 1980 in the body of its opinion, stating that "[P]laintiff asserts that the TCU meets the criteria set forth in the regulation quoted above." There is no dispute that the 1980 regulation was inapplicable to cost report years ending in 1977 and 1978. Thus, the wrong regulation was applied by the District Court. The Court concluded by stating that it could not find the Secretary's interpretation of the regulation to be unreasonable.

The Provider appealed to the United States Court of Appeals for the Sixth Circuit, which affirmed the decision of the District Court.

REASON FOR GRANTING THE WRIT

There Is a Conflict Among the Courts of Appeals With Respect to the Interpretation of 42 C.F.R. §405.452(d)(10) and the Degree of Deference To Be Accorded the Regulatory Interpretation.

The regulation involved in the instant case, 20 C.F.R. §405.452(d)(10), later redesignated as 42 C.F.R. §405.452(d)(10), was passed in 1972. Pursuant to the following criteria listed therein, Blue Cross classified the Provider's TCU as a special care unit for six years and reimbursed it with the higher payments reflective of the increased costs attributable to the operation of special care units:

> *Intensive care units, coronary care units, and other special care inpatient hospital units.*
>
> To be considered an intensive care unit, coronary care unit, or other special care inpatient unit, the

> unit must be a hospital, must be one in which the care required is extraordinary and on a concentrated and continuous basis and must be physically identifiable as separate from the general patient areas. There shall be specific written policies for each of such designated units which include, but are not limited to burn, coronary care, pulmonary care, trauma, and intensive care units but exclude post-operative recovery rooms, post-anesthesia recovery rooms, or maternity labor rooms.

The Provider Reimbursement Manual, a policy guide published by the Health Care Financing Administration, contained the following interpretation of the subject regulation as enacted by the Secretary:

> Special Care Units (Provider Reimbursement Manual, Part 1, §2202.7) (1972).
>
> To be considered a special care inpatient hospital unit, the unit must be in a hospital, must be one in which the care rendered is extraordinary and on a concentrated and continuous basis and must be physically identifiable as separate from general care areas. There shall be specific written policies for each of such designated units which include, but are not limited to, burn, coronary care, pulmonary care, trauma, and intensive care units, but exclude post-operative recovery rooms, post-anesthesia recovery rooms or maternity labor rooms. Segregation of patients to specific areas by type of illness or age, such as psychiatric, neuropsychiatric, geriatric, pediatric, mental health, rehabilitation, etc., does not qualify as special care inpatient hospital units for purposes of apportionment unless the above requirements are met.

The Secretary, in 1977, reinterpreted 42 C.F.R. §405.452(d)(10) to provide as follows:

> Special Care Units (Provider Reimbursement Manual, Part 1, §2202.7)(1977).
>
> A. Requirements to Qualify as an SCU.—To be considered a special care hospital unit, the following requirements must be met:
>
> 1. The unit must be in a hospital.
>
> 2. The unit must be one in which the nursing care required is extraordinary and on a concentrated and continuous basis. *Extraordinary care incorporates extensive life-saving nursing services of the type generally associated with nursing services provided in burn, coronary care, pulmonary care, trauma and intensive care units. For this reason, special life-saving equipment should be routinely available in the unit.*
>
> 3. The unit must be physically identifiable as separate from general care areas *and the unit's nursing personnel must not be integrated with the general care nursing personnel.*
>
> 4. There shall be specific written policies for each of such designated units which include, but are not limited to, burn, coronary care, pulmonary care, trauma, and intensive care units, but exclude postoperative recovery rooms, or maternity labor rooms. *The unit's staff must be specially trained to serve in such areas.* Segregation of patients to specific areas by type of illness or age, such as psychiatric, neuropsychiatric, geriatric, pediatric, mental health, rehabilitation, etc., does not qualify as special care inpatient hospital units for purposes

of apportionment unless the above requirements are met.

* * *

B. Subintensive Units. — Some hospitals have units which provide more intensive care than that provided in the general care areas yet not sufficiently intensive to permit the unit to meet the requirements to qualify as a special care unit under the definition provided in paragraph A above. These units are typically designated as subintensive, subacute, progressive, or intermediate care units, etc. Such subintensive units are not special care units for purposes of Medicare reimbursement.

There may, however, be cases where a unit is not easily identified as a subintensive or special care unit without further study. In such cases, a review of the written policies of the various units will indicate whether a unit is or is not providing care as defined in paragraph A. If the intermediary determines that such a unit meets the requirements of paragraph A above, then the unit will qualify as a special care unit.

For example, one indication of whether the unit in question meets the requirements specified in §2202.7A.2. is the extent of nursing services provided in the unit. If the hours of nursing service per patient day are less than the hours of nursing services provided in an established special care unit, such as an ICU or CCU in that hospital or in other area hospitals if the hospital has no established special care unit, then the unit in question would generally not qualify as a special care unit. Hospitals should maintain such records as are

needed to establish the nursing time in such units. . . . (Emphasis supplied). .

Finally, on May 16, 1979, the Department of Health, Education and Welfare (now Health & Human Services) published its proposed rule for revising once again the definition of special care units. The following comments were made therein:

> This rule *refines* the definition of hospital special care units and *clarifies* the requirements for their reimbursement under the Medicare program. The present special care unit reimbursement regulation has been erroneously interpreted by some hospitals to apply to units that furnish a level of care that is less than that furnished for intensive care.
>
> Under the present regulation, units have been designated as special care units, when they are, in fact, intermediate or subintensive care units that render a less intensive level of care. The purpose of this amendment is to *clarify* the intent of the regulation that the "special care unit" applies only to those units rendering a level of care that is comparable to intensive care.
>
> * * *
>
> Several recent Provider Reimbursement Review Board and Federal court decisions have addressed the issue of whether intermediate or subintensive care units are special care units and have come to *varying conclusions.* These decisions show an existing *lack of uniformity* as to what constitutes a special care unit. In addition, since the regulation was issued, substantial changes have occurred in hospital organization, administration, and financial practices. Increasingly, the inpatient hospital

> special care unit concept has become an acceptable part of medical care practice. We perceive a definite need to further *refine and clear away ambiguity* as to what a special care unit is to Medicare reimbursement purposes. Thus, we propose to amend the regulation. (Emphasis supplied).

The amended version of 42 C.F.R. §405.452(d)(10) appeared on August 18, 1980.

In the instant case, the Provider Reimbursement Review Board, after hearing and evaluating all the testimony and documentary evidence, had no difficulty in finding that the Provider's TCU qualified as a special care unit pursuant to the criteria enumerated in 42 C.F.R. §405.452(d)(10)(1972), adding that it met "both an objective and subjective test" in measuring up to the standards set forth in the regulation. The decision of the Secretary in reversing the PRRB decision, however, contrasted the TCU with the Provider's "recognized" special care units[2] and concluded that it was neither equal nor comparable to them and as such did not qualify for increased reimbursement. In so ruling, the Secretary went beyond the plain meaning of the requirements of the published regulation.

Judicial review of the Secretary's determination is governed by the Administrative Procedure Act, 5 U.S.C. §701 *et seq.* Where, as here, the court's review

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[2]The Provider operates an Intensive Care Unit, Coronary Care Unit, Burn Unit, and Neonatal Unit in addition to its Transitional Care Unit. All have been consistently treated by Blue Cross as special care units with the exception of the TCU, which Blue Cross also treated as a special care unit from 1971 through 1976.

was based upon the record of a hearing before an administrative agency, this statute provides that the Court need only find that the Secretary's ruling was not supported by "substantial evidence." The Court must "review the whole record or those parts of it cited by a party." 5 U.S.C. §706.

In the instant case the Board decision was reviewed by a Deputy Administrator of the Health Care Financing Administration ("HCFA") who was delegated such review authority by the Secretary. The District Court held, and the Court of Appeals affirmed, that it was within the discretion of the Secretary to compare the TCU with *two* of the Provider's *four* acknowledged special care units and determine that the level of care provided by the TCU was not as "high" as that of the other two. This degree of deference granted by the Sixth Circuit to the Secretary's interpretation of her own regulation is improper and unwarranted. As stated in *Central Washington Health Services Association* v. *Harris,* 497 F. Supp. 1143, 1152 (E. D. WA. 1980) in the following words:

> While the "substantial evidence" standard of review does not allow a reviewing court to substitute its judgment for that of the agency, the review under this standard is not to be a superficial or cursory review. The court's inquiry must be *searching and careful,* subjecting the agency's decision to close judicial scrutiny. Likewise, the reviewing court is not confined to those portions of the record, if any, which the agency cites in support of its conclusions. *The court is charged*

to review the record as a whole. (Emphasis supplied).

Further, the Court in *Central Washington* followed the ruling of this Court in *Universal Camera Corp.* v. *National Labor Relations Board,* 340 U. S. 474 (1951) in acknowledging that while the substantial evidence standard is not modified in any way when the agency (Administrator) and the examiner (Provider Reimbursement Review Board) disagree, the conclusion reached by the agency should be scrutinized when it is contrary to that of an "impartial, experienced examiner" (Board) who has "observed the witnesses and lived with the case." *Id.*

The question of substantial evidence review was also ruled upon by the Third Circuit when, on June 17, 1982 it affirmed without opinion a district court decision adverse to the Secretary. In *Saint Luke's Hospital of Bethlehem, Pennsylvania* v. *Schweiker,* (E. D. PA. 1981), CCH Medicare and Medicaid Guide, ¶31,501, 668 F. 2d 824 (3d. Cir. 1982), the Board held in favor of the hospital, finding that its Concentrated Care Unit qualified for Medicare reimbursement as a special care unit. The Secretary reversed the Board's decision and the hospital appealed to district court. The U.S. District Court for the Eastern District of Pennsylvania granted recognition of the provider's Concentrated Care Unit as a special care unit pursuant to 42 C.F.R. §405.452 (d)(10).

In its decision, the court commented on the degree of deference to be afforded the Secretary's determination as follows:

> Certainly, the fact that the Administrator reversed a decision within the agency is sufficient to require *close scrutiny* by this court. This is especially so since the PRRB, a five member board, has members which are required by statute to be "knowledgeable" in the field of cost reimbursement, and at least one PRRB member is required to be a certified public accountant. 42 U.S.C. §1395oo(h). As stated in *St. John's Hickey Memorial Hospital* v. *Califano,* 559 F. 2d 803 (7th Cir. 1979), it is not appropriate for the courts to afford the Secretary's position extreme deference.
>
> Paragraph 31,501 at p. 9465 (Emphasis supplied).

In *St. John's Hickey Memorial Hospital, Inc.* v. *Califano,* 559 F. 2d 803, 813 (7th Cir. 1979) referred to above, the PRRB found for the provider and was reversed by the Health Care Financing Administration. The Secretary insisted that the interpretation of the statute by the agency directed to administer it was entitled to great deference. However, the Seventh Circuit disagreed in the following words:

> . . . a review of the cases reveals that the degree of deference to be accorded agency action varies with the circumstances, and a careful consideration of the Medicare statute and the manner in which it has been administered reveals that such deference would be particularly inappropriate in this case where we are not setting aside any regulation but only disagreeing with an unofficial interpretation of it.
>
> * * *
>
> . . . the statute specifically creates the right to judicial review of the Secretary's adverse ruling

> on what costs are reimbursable, thus reserving to the courts the final authority to interpret this aspect of the statute (42 U.S.C. §1395oo(f)).

The Court of Appeals continued in a footnote as follows:

> This special provision for judicial review is not surprising in light of the statutory scheme. Here the plaintiff is not the beneficiary of the government program, but a necessary participant in carrying out the program. The Secretary is obligated by statute to reimburse all reasonable costs of such providers. *It would be inappropriate to allow his subordinates to be the final arbiter of what is reasonable, particularly when they have overruled the decision of the Provider Reimbursement Review Board which was set up to mediate disputes between providers and intermediaries acting for the agency.* (Emphasis supplied).

The Seventh Circuit reiterated its position in *Community Hospital of Indianapolis, Inc.* v. *Schweiker,* 717 F. 2d 372, 375-376 (1983) in the following words:

> The Secretary argues that the [Provider Reimbursement] manual definition of a special care unit is entitled to great deference because the Health Care Financing Administration is likely to know more about the underlying intent of 42 C.F.R. §405.452(d) (10) than the courts. Under the circumstances of this case, however, such deference is not warranted. As the Supreme Court noted in *Bowles* v. *Seminole Rock & Sand Co.,* 325 U. S. 410 (1945), "a court must . . . look to the administrative construction of the regulation if the meaning

> of the words used is in doubt." *Id.* at 414. *The plain meaning of the words used in 42 C.F.R. §405.452(d)(10) allows . . . no such doubt here. The regulation itself in no way suggests that special care unit status is to be limited to patient care areas where extensive lifesaving services are available.*
>
> * * *
>
> Thus, we reject the Secretary's argument that we must defer to the Provider Reimbursement Manual Revision as the dispositive indicator of the regulation's intent. (Emphasis supplied).

The same approach to judicial review of administrative action is found in *St. James Hospital* v. *Heckler,* 579 F. Supp. 757 (N. D. Ill. 1984). Citing *Bureau of Alcohol, Tobacco & Firearms* v. *Federal Labor Relations Authority,* 104 S. Ct 439, 444 (1983) and *American Ship Building Co.* v. *NLRB,* 380 U. S. 300, 318 (1965), the court stated that "... the judicial deference usually afforded to an agency's determination of how best to achieve statutory policies enacted by Congress 'cannot be allowed to slip into judicial inertia.'" It continued as follows:

> Courts "are not obliged to stand aside and rubberstamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute." *NLRB* v. *Brown,* 380 U. S. 278, 291 (1965). Moreover, "[i]f Congress established a presumption from which judicial review should start, that presumption . . . [is] *against* changes in current policy that are not justified by the rulemaking record." *Motor Vehicle Manufac-*

> *turers Association of the United States, Inc.* v. *State Farm Mutual Automobile Insurance Co.*, 103 S. Ct. 2856, 2866, 77 L. Ed. 2d 443 (1983) (Emphasis in original).

In contrast to the rationale of the Third and Seventh Circuits, the D.C., Fourth, Fifth, and Ninth Circuits have based their decisions upon due deference to the agency interpretation of its own regulations. See *White Memorial Medical Center* v. *Schweiker,* 640 F. 2d 1126, 1129 (9th Cir. 1981); *Psychiatric Institute of Washington, D.C., Inc.* v. *Schweiker,* 669 F. 2d 812, 813-814 (D. C. Cir. 1981); *Sun Towers, Inc.* v. *Schweiker,* 694 F. 2d 1036, 1038 (5th Cir. 1983); *Lexington County Hospital* v. *Schweiker,* 740 F. 2d 287 (4th Cir. 1984).

The regulation before the Court affects not only the Petitioner herein, but all the aged and disabled beneficiaries of the Medicare program for whom special care units provide a level of hospital care that cannot be equated merely with dollars and cents, but with lives. Recognition of the Provider's TCU as a special care unit pursuant to 42 C.F.R. §405.452(d)(10) is consistent with the statutory principle of payment for the reasonable and necessary costs of services provided to Medicare beneficiaries, and the goals of the Medicare Act.

CONCLUSION

The Petitioner herein, NKC, Inc., respectfully submits to the Court that its Transitional Care Unit met the requirements of extraordinary, concentrated and

continuous care pursuant to the regulation in effect during the cost reporting periods in dispute. Both the Third and Seventh Circuit Courts of Appeals have decided in favor of the interpretation of 42 C.F.R. §405.452(d)(10)(1972) urged by the Petitioner.

From 1971 through 1976 the Transitional Care Unit in issue was reimbursed under the Medicare program as a special care unit. Yet in 1977 and 1978 this *same* unit was denied the recognition afforded by Blue Cross for the previous six cost report years.

The unanimous determination of the Provider Reimbursement Review Board that the TCU qualified as a special care unit was reversed by the Secretary in an arbitrary and capricious manner. The District Court upheld the Secretary in an opinion based upon a regulation in effect for cost report years *subsequent* to those in issue. The Sixth Circuit compounded the error of the lower court by holding that the Secretary's interpretation of the regulation retroactively applied to the Petitioner was not unreasonable.

The Petitioner respectfully requests that the Court address the issues set forth above and grant the Petition for Writ of Certiorari.

Respectfully submitted,

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APPENDIX

RECOMMENDED FOR FULL TEXT PUBLICATION
See, Sixth Circuit Rule 24

No. 83-5864

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

NKC, Inc. - - - - - - *Plaintiff-Appellant,*

v.

Secretary of Health and Human Services - - - - - - *Defendant-Appellee.*

On Appeal From the United States District Court for the Western District of Kentucky

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Decided and Filed November 15, 1984

Before: Edwards and Keith, Circuit Judges; and Brown, Senior Circuit Judge.

Edwards, Circuit Judge. NKC, Inc., plaintiff-appellant, in this appeal operates the Norton-Children's Hospital, Inc., a 492 bed hospital in Louisville, Kentucky. As a part of its hospital operation, Norton's operates a unit which it terms its Transitional Care Unit. Norton's also operates in the same hospital an Intensive Care Unit, a Coronary Care Unit, a Burns Unit and a Neo-Natal Unit. From 1971 to 1976 all of these previously named units were treated by Blue Cross as "special care units" for purposes of reimbursement under the Medicare Program. However, for the years 1977 and 1978, reimbursement at the special care unit rate was continued as to each of these units except for the Transitional Care Unit. As to it (TCU), Blue Cross denied payment at the special care unit rate and NKC, Inc. appealed.

After a hearing before the Department of Health and Human Services Appeal Board, the Board issued a unanimous decision in favor of granting TCU special care unit treatment.

Nonetheless, this decision was reversed by the Deputy Administrator of Health Care Financing Administration, where upon NKC, Inc. filed for judicial review before the United States District Court for the Western District of Kentucky pursuant to 42 U.S.C. § 1395oo(f). The District Judge denied NKC's motion for summary judgment and granted the Secretary's motion for judgment on the pleadings whereupon this appeal was filed before this court.

This court has now received full briefing and has heard full oral argument from the parties. It appears that decision of this case hinges upon answers to two questions:

> 1. Is the Secretary's interpretation of § 405.452(d)(10), as requiring the same level of care as Intensive Care Units and Cardiac Care Units rather than simply greater care than in routine care units, rational and in accordance with the Medicare Act?
> 2. Is the determination of the Secretary in denying special care unit status to the TCU supported by substantial evidence?

On full consideration of this record, including briefs and oral arguments, we answer both of these questions in the affirmative. We note at the outset that 42 C.F.R. § 405.452(d)(10) reads as follows:

> *Intensive Care Units, Coronary Units and Other Special Care Inpatient Hospital Units.*
>
> To be considered an intensive care unit, coronary care unit, or other special care inpatient hospital unit, the unit must be in a hospital, must be one in which the care required is extraordinary and on a concentrated and continuous basis and must be physically identifiable

> as separate from general patient care areas. There shall be specific written policies for each of such designated units which include, but are not limited to burn, coronary care, pulmonary care, trauma, and intensive care units but exclude post-anesthesia recovery rooms, or maternity labor rooms.

We deduce that beginning in 1977 the interpretation of this regulation was changed to require that a unit must provide the same level of care as that provided by intensive care and cardiac care units in order that it be treated as a special care unit. This interpretation has provoked controversy in a number of cases in the courts of appeal. In the following cases, courts of appeal have followed the Secretary's interpretation. *Sun Towers, Inc.* v. *Schweiker,* 694 F. 2d 1036 (5th Cir. 1983) (compared the unit in question to the highest level of care provided by the institution—the unit provided less care and therefore should not be considered a special care unit); *White Medical Center* v. *Schweiker,* 640 F. 2d 1126 (9th Cir. 1981) (used same approach as used in *Sun Towers*); *Psychiatric Institute of Washington, D.C., Inc.* v. *Schweiker,* 669 F. 2d 812 (D.C. Cir. 1981) (compared unit to special care units in the same institution—the unit provided care less concentrated and less continuous and therefore should not be considered a special care unit); *Villa View Community Hospital* v. *Heckler,* 728 F. 2d 539 (D.C. Cir. 1984) (followed *Psychiatric Institute* and reversed district court in companion case cited by appellant—*Los Alamitos General Hospital, Inc.* v. *Donnelly,* No. CA-79-0668 (D.D.C. Feb. 28, 1983)); *Lexington County Hospital* v. *Schweiker,* 740 F. 2d 287 (4th Cir. 1984) (approved interpretation that unit must provide care equivalent to that provided in special care units).

In several instances, the Secretary's interpretation has been rejected by courts of appeal. *Community Hospital of Indianapolis, Inc.* v. *Schweiker,* 717 F. 2d 372 (7th Cir.

1983) (rejected interpretation that unit must provide care *identical* to that provided in recognized special care units but required that the unit provide *comparable* care—court held unit was closer to special care unit than to routine care and therefore should be considered a special care unit); *St. Luke's Hospital of Bethlehem, Pa.* v. *Schweiker*, 668 F. 2d 824 (3d Cir. 1982) (affirmed without opinion district court which held that the Secretary's interpretation that intensive care was required for a unit to be a special care unit was unreasonable—regulation only required that care be extraordinary, continuous and concentrated).

It appears in our instant situation that the Transitional Care Unit is staffed and equipped so as to provide care definitely superior to routine hospital care. It likewise appears clear to this court that this record would not allow for a finding that the Transitional Care Unit operated at the Norton-Children's Hospital provided as high a level of care as the Intensive Care Unit and Cardiac Care Units.

While we recognize that the District Judge in this case made reference to the new, rather than the old, regulation, we nonetheless feel that the District Judge's decision was correct. We hold that it is within the Secretary's discretion to compare the Transitional Care Unit with the Intensive Care Unit and the Cardiac Care Unit and determine that its level of care, while clearly above ordinary hospital care, is not as high as the other two special care units.

The Administrative Procedures Act, 5 U.S.C. § 701 et seq. allows the District Court and this court to set aside findings and conclusions of an agency which are "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with the law."

We now find from our review of the record that the Secretary did not abuse her discretion in this case and that her decision was made with support of substantial evidence. The judgment of the District Court is therefore affirmed.

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

No. 83-5864

NKC, INC., - - - - - *Plaintiff-Appellant,*

v.

SECRETARY OF HEALTH AND HUMAN SERVICES, - - - - - *Defendant-Appellee.*

JUDGMENT — Filed November 15, 1984

Before: EDWARDS, and KEITH, Circuit Judges; and BROWN, Senior Circuit Judge.

ON APPEAL from the United States District Court for the Western District of Kentucky.

THIS CAUSE came on to be heard on the record from the said District Court and was argued by counsel.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this court that the judgment of the said District Court in this case be and the same is hereby affirmed.

It is further ordered that Defendant-Appellee recover from Plaintiff-Appellant the costs on appeal, as itemized below, and that execution therefor issue out of the said District Court, if necessary.

Entered by Order of the Court
John P. Hehman, Clerk
(s) John P. Hehman
Clerk
A True Copy.
Attest:
(s) Audrey Crockett, Deputy Clerk

UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF KENTUCKY
AT LOUISVILLE

No. C 82-0200-L(B)

NKC, Inc. - - - - - - - - *Plaintiff*

v.

Richard S. Schweiker, Secretary of Health and Human Services - - - *Defendant*

MEMORANDUM

This matter is before the Court on the motion of the plaintiff for summary judgment and on the motion of the defendant for judgment on the pleadings.

Plaintiff, NKC, Inc., operates a short-term acute care hospital with about 500 beds. Within its hospital plaintiff operates a coronary care unit (CCU), an intensive care unit (ICU), a burn unit, a neonatal unit, and a transitional care unit (TCU). It is the last unit that is the focal point of this litigation.

This action arises under the Medicare Act, Title 42 U.S.C. Section 1395 et seq. Plaintiff is a "provider of services" as that term is defined in 42 U.S.C. Section 1395x (u). As a provider it is entitled to reimbursement for the reasonable cost of furnishing medical care to Medicare beneficiaries. To accomplish this reimbursement the Secretary has promulgated regulations, 42 C.F.R. Section 405.401 to 405.488. Reimbursement is generally accomplished after an audit by a fiscal intermediary—in this case Blue Cross-Blue Shield—which may disallow certain costs. If a provider is dissatisfied with the final audit report and explanation of audit adjustments, it may appeal to the

Provider Reimbursement Review Board (PRRB) which may affirm, modify or reverse the intermediary's determination. The Secretary or his designee may affirm, modify or reverse the decision of the PRRB. A provider which receives an adverse decision of the Secretary may bring an action for judicial review in the appropriate United States District Court.

Plaintiff made claim for reimbursement of costs of care rendered in its TCU, adopting the position that the TCU was an intensive care type inpatient hospital unit as defined in 42 C.F.R. Section 405.452(d)(10):

> (10) *Intensive care type inpatient hospital unit.* To be considered an intensive care type inpatient hospital unit, the unit must furnish services to critically ill patients. (Examples of intensive care type units include, but are not limited to, intensive care units, trauma units, coronary care units, pulmonary care units, and burn units. Excluded as intensive care type units are postoperative recovery rooms, post-anesthesia recovery rooms, maternity labor rooms, and subintensive or intermediate care units.) The unit must also meet the following conditions;
>
> (i) The unit must be in a hospital;
>
> (ii) The unit must be physically and identifiably separate from general routine patient care areas, including subintensive or intermediate care units, and ancillary service areas. There cannot be a concurrent sharing of nursing staff between an intensive care type unit and units or areas furnishing different levels or types of care. However, two or more intensive care type units that concurrently share nursing staff can be reimbursed as one combined intensive care type unit if all other criteria are met. Float nurses (nurses who work in different units on an as-needed basis) can

be utilized in the intensive care type unit. If a float nurse works in two different units during the same eight hour shift, then the costs must be allocated to the appropriate units depending upon the time spent in those units. The hospital must maintain adequate records to support the allocation. If such records are not available, then the costs must be allocated to the general routine services costs areas;

(iii) There must be specific written policies that include criteria for admission to, and discharge from, the unit.

(iv) Registered nursing care must be furnished on a continuous 24-hours basis. At least one registered nurse must be present in the unit at all times;

(v) A minimum nurse-patient ratio of one nurse to two patients per treatment day must be maintained. Included in the calculation of this nurse/patient ratio are registered nurses, licensed vocational nurses, and nursing assistants who provide patient care. Not included are general support personnel such as ward clerks, custodians and housekeeping personnel; and

(vi) The unit must be equipped, or have available for immediate use, life-saving equipment necessary to treat the critically ill patients for which it is designed. This equipment may include, but is not limited to, respiratory and cardiac monitoring equipment, respirators, cardiac defibrillators, and wall or canister oxygen and compressed air.

The intermediary disallowed the claim and plaintiff appealed to the PRRB which reversed the intermediary and approved the claim for payment. Thereafter, the Secretary's designee set aside the decision of the PRRB and disallowed plaintiff's claim. This action, seeking a review of that decision, was then commenced in this Court.

The administrative record contains almost 400 pages of testimony introduced before the PRRB. The substance of that testimony may fairly be said to establish that plaintiff's TCU affords more intensive monitoring of patients than is available to the general hospital population.

On the other hand, it may also be fairly said that the TCU does not afford the highly sophisticated and intensive monitoring which is a part of the routine of the CCU and the ICU.

Plaintiff asserts that the TCU meets the criteria set forth in the regulation quoted above. The Secretary equated the TCU with subintensive or intermediate care units.

It is well settled that judicial review of the Secretary's determination is limited by the standards of the Administrative Procedures Act. Title 5 U.S.C. Section 701 et seq.

Section 706(2)(A) and (E) of the Act provides:

> [The reviewing court shall] (2) hold unlawful and set aside agency action, findings, and conclusions found to be—
>
> (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
>
> * * * *
>
> (E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute. . . .

Plaintiff's argument rests on its position that the Secretary should compare its TCU with the routine care facility conducted by plaintiff. While this argument has some appeal, the Court concludes that the Secretary is vested with discretion to compare the TCU with the ICU and the CCU. Substantial evidence to support the Secre-

tary's conclusion may be found in the testimony of Drs. Michael Flynn and Stuart Graves.

Dr. Flynn testified by deposition:[1]

"Q. 44. Would you agree that the Transitional Care Unit is basically for patients well enough not to be in the Intensive Care Unit or Coronary Care Unit, but not sufficiently recovered to be in the routine area?

A. That is one classification of patient that can be in there, yes.

* * * * * * *

Would you agree that the Transitional Care Unit is a Sub-Intensive Care Unit?

A. Well, you know, I am not exactly sure what you mean. I would say it is a Special-Care area. That isn't quite as—doesn't really—does not—in certain circumstances, does not provide quite the same level of intensive care as the Intensive Care Unit.

Now, you know, you are asking me to, you know, Sub-Intensive Care Unit, you'll have to really define that for me before I know what you are talking about.

But it is an Intensive Care Unit which doesn't provide quite the same level of intensive care, in that the patients are not in an open ward, so they are not subjected to the constant visual monitoring; they do not use respirators, and they don't have quite the number of nurses, so that they obviously can't provide the same intensive level of nursing care just because they don't have the numbers.

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[1]The pages of the transcript of evidence are not numbered in sequence. Dr. Flynn's deposition begins after page 120 of the administrative hearing which is included in volume 2 of the record. Dr. Grave's deposition follows Dr. Flynn's.

Now, if that's what you mean by Sub-Intensive Care Unit, yes, I would agree with that." (Flynn deposition pp. 25, 35.)

Dr. Graves testified by deposition:

Q. 21. Is there any other distinction between the quality of nursing care rendered in TCU and that rendered in the routine area of the hospital?

A. I don't know that there's any difference in quality. There is certainly a difference in quantity.

Q. 22. All right.

A. We like to think — I'm biased towards the Norton's, incidentally, but we like to think all of our nurses are very qualified, and with the exception of this cardiac training, I think they all are. I think all our nurses are as good as our ICU or TCU nurses. We just have a lot more of them.

Q. 23. When you talk about the quantity, you're saying you have a lot more of them, meaning there's a higher ratio of nursing care per patient rendered in the TCU than in the routine area?

A. Considerably higher.

* * * * * * *

Q. 44. Would you agree, Doctor, that the level of care offered in the transitional care unit is of a lesser level than that offered in the coronary care unit or the intensive care unit, again, not from a quality standpoint, but from a quantity standpoint?

A. Yes.

Q. 45. Are you familiar with the written policies of the transitional care unit?

A. You mean, can I quote them to you? I can't do that.

Q. 46. No. But are you generally familiar with them?

A. I think so.

Q. 47. Would you agree that those policies indicate that the purpose of the transitional care unit is to care for patients who were well enough to be out of the intensive care unit or the coronary care unit but not well enough to go to the medical-surgical wards?

A. Yes.

* * * * * * *

Q. 59. You testified that the transitional care unit offers more nursing care, again, from a quantity standpoint than the routine medical-surgical ward would offer?

A. Yes, sir.

Q. 60. Would you also agree that the ICU or CCU offers more nursing care from a quantity standpoint than the TCU?

A. From a quantity standpoint?

Q. 61. Yes, sir.

A. Yes." (Graves deposition, pp. 10, 19-20, 22.

In *Psychiatric Institute, Etc.* v. *Schweiker,* 669 F. 2d 812 (D.C. Cir. 1981), the court treated an argument similar to that advanced by plaintiff here. In rejecting the argument the court wrote:

> "Judicial review of such determinations is limited by the familiar standards of 5 U.S.C. [Section] 706 (1976). Furthermore, where the decision under review involves an agency's interpretation of its own regulations, forming part of a complex statutory scheme which the agency is charged with administering, the arguments or deference to administrative expertise

are at their strongest. *See Ford Motor Credit Co.* v. *Milhollin,* 444 U. S. 555, 566, 100 S. Ct. 790, 797, 63 L. Ed. 2d 22 (1980). A reviewing court may not set aside the agency's interpretation merely because another interpretation was possible and seems better, so long as the agency's interpretation is within the range of reasonable meanings that the words of the regulation admit."

The *Psychiatric Institute* court followed the lead of the Ninth Circuit in *John Muir Memorial Hospital, Inc.* v. *Schweiker,* 664 F. 2d 1337 (1981), where the Court noted:

"The Memorial Hospital of Gardena and the John Muir Memorial Hospital established 'Maxicare' and 'Definite Care' units, respectively, to provide intermediate care to patients who did not require intensive care but who were too seriously ill to be cared for on general medical-surgical floors. The hospitals classified these units as 'special care units' (SCUs) and applied for the higher SCU per diem reimbursement.

The Secretary decided in each case that the care provided in the units was not 'extraordinary and on a concentrated and continuous basis,' and that the units did not qualify as SCUs under the definition in 42 C.F.R. [Section] 405.452(d)(10). Both district courts found that, because the care rendered in the intermediate units was greater than that provided on a general floor, a higher per diem was appropriate.

We shall not disturb the Secretary's findings that the units are not SCUs, our decision being controlled by *White Memorial Medical Center* v. *Schweiker,* 640 F. 2d 1126 (9th Cir. 1981). *White* established that the regulation defining SCUs was an *ejusdem generis* one, limiting its coverage to units similar to those enumerated. The Secretary's interpretation calling for com-

parison to enumerated units, not routine service floors, is reasonable. Complex accounting methods used to distribute medicare funds are involved. *Id.* at 1129. We defer to the Secretary's expertise.

The Secretary decided in *White,* and here, that the intermediate care units did not deliver care similar to that in burn, coronary, pulmonary, trauma, or intensive care units. Although both hospitals produced evidence that their units deliver 'extra-ordinary' care, substantial evidence supports the Secretary's conclusions."

If this Court were writing on a clean slate, we would have no hesitancy in finding that plaintiff's TCU meets the criteria of the regulation. We cannot say, however, that the TCU admits of no other interpretation and we cannot conclude that the Secretary's interpretation of the regulation is unreasonable.

The Court concludes that defendant's motion for judgment on the pleadings should be granted and plaintiff's motion for summary judgment should be denied.

An appropriate order has been entered this date.

September 27, 1983

(s) Thomas A. Ballantine, Jr.
Thomas A. Ballantine, Jr.
United States District Judge

Copies to:

Counsel of record

UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF KENTUCKY
AT LOUISVILLE

No. C 82-0200-L(B)

NKC, INC. - - - - - - - - - *Plaintiff*

v.

RICHARD S. SCHWEIKER, Secretary of
Health and Human Services - - - *Defendant*

ORDER — Entered September 27, 1983

For the reasons set forth in the memorandum filed this date,

IT IS ORDERED that the motion of the plaintiff for summary judgment on its claim against the defendant be and hereby is denied.

IT IS FURTHER ORDERED that the motion of the defendant for judgment on the pleadings be and hereby is granted, and this action is dismissed with prejudice.

There is no just reason for delay, and this is a final and appealable Order.

This 27th day of September, 1983.

(s) Thomas A. Ballantine, Jr.
Thomas A. Ballantine, Jr.
United States District Judge

Copies to:

Counsel of record

[LETTERHEAD OF DEPARTMENT OF HEALTH & HUMAN SERVICES]
Office of Attorney-Advisor

Carson P. Porter, Esq.
Reisz, Rice, Porter & Rosenbaum
1207 Citizens Plaza
Louisville, Kentucky 40202

Dear Mr. Porter:

Re: *Norton-Children's Hospitals, Inc.*, v. *BCA/BC/Blue Shield of Kentucky, Inc.*, Determination of Reasonable Costs for Cost Reporting Periods Ending 12/31/77, and 12/31/78, PRRB Decision No. 82-D24.

Enclosed is a copy of the Deputy Administrator's decision in the above case. This decision reverses the decision of the Provider Reimbursement Review Board.

If the Provider wishes to obtain judicial review of the matter, civil action must be initiated within 60 days of the date the Administrator's decision is received. For your ready reference, I enclose a copy of Section 1878(f) of the Social Security Act, as amended [42 USC 1395oo(f)].

Sincerely yours,

(s) Erica L. Gosnell
Erica L. Gosnell, Director
Office of Attorney-Advisor

Enclosures

DECISION OF THE DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION DATED FEBRUARY 4, 1982

Norton-Children's Hospitals, Inc., v. *BCA/BC/Blue Shield of Kentucky, Inc.*, Determination of Reasonable Costs for Cost Reporting Periods Ending 12/31/77, and 12/31/78, PRRB Decision No. 82-D24

Provider Reimbursement—Determination of Costs of Services—Special Care Units—Where the patients in the Transitional Care Unit required a significantly lesser level of care than patients in the Provider's established special care units, the Deputy Administrator found that the patients did not require extraordinary care on a concentrated and continuous basis and held that the Transitional Care Unit did not supply all of the criteria of 42 CFR 405.452(d)(10) to be considered a special care unit. [NOTE: This issue follows the Administrator's previous decisions on review of PRRB Decisions Nos. 77-D76, 77-D83, 78-D72, 79-D3, 79-D24, 79-D70, 79-D87, 79-D98, 80-D28, 80-D29, 80-D35, 80-D36, 80-D49, 80-D65, 80-D101, 81-D34, 81-D65, 81-D80, 81-D82, 81-D90, and 82-D20].

PRRB Decision No. 82-D24, at Commerce Clearing House, *Medicare and Medicaid Guide* ¶ , is reversed.

HEALTH CARE FINANCING ADMINISTRATION

Decision of the Administrator

In the Case of:

NORTON-CHILDREN'S HOSPITALS, INC. - - *Provider*

v.

BLUE CROSS ASSOCIATION/BLUE CROSS/
BLUE SHIELD OF KENTUCKY, INC. - *Intermediary*

Claim for:

Provider Cost Reimbursement
Determination of Reasonable Costs for Cost Reporting Period(s) Ending December 31, 1977 and December 31, 1978

Review of:

PRRB Decision No. 82-D24
Dated: December 10, 1981

This case is before the Deputy Administrator, Health Care Financing Administration, for review of the decision of the Provider Reimbursement Review Board. The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act, as amended [42 USC 1395oo(f)]. Comments were received from the Intermediary requesting reversal of the Board's decision. The Parties were notified that the Board's decision would be reviewed in light of the Administrator's Decision in PRRB Decision No. 77-D76. No comments were received from the Provider. Accordingly, this case is now before the Deputy Administrator for final administrative decision.

THE ISSUE AND PRRB OPINION

The issue concerns whether the costs and statistics of the Provider's Transitional Care Unit (TCU) should be

classified as routine care costs or special care costs for the December 31, 1977 and 1978 cost years at issue. The appeal involves whether the Provider's TCU renders care to patients who require extraordinary care on a concentrated and continuous basis so as to qualify the TCU as a special care unit. The Board held that the TCU qualifies as a special care unit for Medicare reimbursement purposes.

SUMMARY OF INTERMEDIARY'S COMMENTS

Counsel for the Intermediary requested reversal of the Board's decision. The Intermediary noted that the hospital's written policies, as well as the statistics concerning the average number of nursing hours per patient day, costs per patient day, patient transfers and discharges, and equipment availability indicate that the Provider's Transitional Care Unit is a step-down unit to the recognized special care areas, the Intensive Care Unit and the Coronary Care Unit.

The Intermediary commented that the Board had ignored the written policies of the TCU and erred in rejecting the actual cost comparisons. Instead, the Board relied on hypothetical statistics adjusted for differences to a 90% occupancy level.

The Intermediary wrote that the Board was also in error when it relied on the Administrator's decision in *Loyola University of Chicago,* PRRB Decision No. 81-D54. The Intermediary noted that the nurse-to-patient ratio used in *Loyola* was not the only pertinent comparison in this case. The Board should have considered others. In *Loyola* the unit in question rendered the same type of care as in that provider's recognized special care units. This was not true for this Provider's TCU.

Further, the Intermediary commented that the Board erred in comparing the TCU to the Provider's neonatal

unit. The neonatal unit is an intensive care nursery and should not be compared to units serving adults.

LAW, REGULATIONS, AND OTHER GOVERNING CRITERIA

The provisions of the Law, Regulations, and other governing criteria relied on in this decision are quoted in the attached which is incorporated by reference and is to be read as a part of this decision.

DISCUSSION AND EVALUATION

All the evidence that was furnished by the Provider Reimbursement Review Board has been considered, including the exhibits, transcript of the oral hearing before the Board, sworn testimony of the witnesses, position papers, photographs, and the parties' post-hearing briefs. All communications and comments received from and sent to the parties after entry of the Board's decision have been made a part of the record. The complete statement of facts set forth by the Board is incorporated by reference.

The Deputy Administrator has carefully reviewed the factors in this case in light of the Board's decision. Great weight has been given to the findings of the Board. However, the Administrator does not agree with the Board's decision and is of the opinion that the decision that the unit under appeal is a special care unit is not substantiated by the probative records and is not in keeping with the regulations.

At issue in this case is not so much the question of facts as is the inference to be drawn from them and the interpretation of them in light of the Medicare law and regulations. In this regard, it is noted that under the Administrative Procedure Act (5 USC 557(b)), this agency has all the powers on review that "it would have in making

the initial decision . . . ." That Act, of course, gives the basic precept governing all administrative proceedings throughout the U.S. Government. There is nothing in the Medicare legislation [42 USC 1395oo] that provides to the contrary.

The Board's decision is based on a finding that the care required for patients in the unit at issue was extraordinary and on a concentrated and continuous basis. An analysis of the governing regulation, 42 CFR 405.452(d)(10), shows that the terms "extraordinary", "concentrated", and "continuous" do not lend themselves to precise definition. These terms should be understood within the meaning as applied to the special care units listed in the Regulation. The Regulation lists burn, coronary care, pulmonary care, trauma, and intensive care units as examples of qualifying units. The listing of existing units which would generally meet the definition of a special care unit establishes the frame of reference against which to measure newly established units in order to determine whether they provide "extraordinary" care "on a concentrated and continuous basis."

The Regulation's listing of various special care units which meet the extraordinary, concentrated, and continuous care requirement indicates the specific class of units to which the general words, "extraordinary" "concentrated" and "continuous", apply. As such, the Regulation's extraordinary, concentrated and continuous requirement applies only to units which are of the same class as those specifically listed. Thus, a qualifying unit must be comparable to the recognized units listed in the Regulation rather than merely one that renders care over and above that which is rendered in the routine area.

Webster's Dictionary defines "extraordinary" as "being beyond what is usual, regular, customary or exceptional to a very marked extent." The Board's interpretation of

"extraordinary" may rest on Webster's definition that it is "beyond what is usual, regular or customary." It is the Deputy Administrator's opinion that the context in which "extraordinary" is used in the Regulation, establishes that it means "exceptional to a very marked extent." Extraordinary care under the Regulation is exceptional care which is absolutely required of patients admitted to special care units. Patients who require extraordinary care are those who are critically ill and in immediate life-threatening situations. If a unit treats, and is designed to treat patients who are convalescing and whose conditions are improving to the point where they are not critically ill, the unit is usually not rendering extraordinary care. The patients in such a unit do not absolutely require extraordinary care.

The terms "concentrated and continuous" as used in 42 CFR 405.452(d)(10) are no less easily defined than the term "extraordinary." The requirement of extraordinary care on a concentrated and continuous basis means that the care must be focused on a relatively small number of patients constantly. The care rendered is not on a concentrated and continuous basis if the patients receiving it are not constantly being monitored or if direct visual observation of the patients is not possible at all times. The latter requirement is emphasized in the JCAH Manual which states that in special care units "direct visual observation of all patients should be possible from a central vantage point." Thus, patients who are not constantly monitored and who are free to move about independently within a unit are not receiving extraordinary care on a concentrated and continuous basis, as those terms are used in the Regulation.

The care in a qualifying special care unit must either meet the definition of 42 CFR 405.452(d)(10), or be treated as a part of the routine area. The unit at issue in this appeal is specifically referred to as the Transitional Care

Unit (TCU). The unit is "intermediate" because it treats patients who require care greater than routine, but less than special. Even though the care rendered in a unit may be more than that rendered in an average routine area, this does not make that unit a special care unit. The Medicare Regulations recognize only special and routine care for cost apportionment purposes. A unit which does not qualify as special care must be considered routine.

While many of the patients in the TCU were admitted postoperatively, the record reflects that approxiately one-half of the patients are transferred from the Coronary and Intensive Care Units (CCU and ICU). These patients are usually transferred after their conditions have improved and they are convalescing. The unit is not equipped as extensively as the hospitals' CCU and ICU. The testimony by the Provider's witnesses established that patients transferred to the unit under appeal were still very ill and required care greater than that available in other routine areas. The fact that some of these patients may still require a higher level of care than that available in a routine area does not, however, establish that the unit is a special care unit under the Regulation.

A comparison of the unit in question to the same hospital's recognized special care units reveals that the unit in question renders a step-down or intermediate level of care. The policy governing the unit provides that the critically ill patients who are placed in the recognized special care units, the ICU or CCU, will be transferred to the TCU after they have been found well enough to leave the ICU and CCU.

The level of nursing care provided in the TCU is reflected in the average number of nursing hours per patient day. These statistics, when compared to those of the established special care areas, show that the nursing hours supplied in the TCU are less than those supplied in the Pro-

vider's established special care areas. The nursing cost ratios in these units also show that the TCU supplied a lesser level of nursing care.

A breakdown of the average number of nursing hours per patient day, unit costs per patient day (before and after step-down allocation), hourly nursing charges, and nursing costs per patient day shows the ratio in the established special care units to be consistently greater than the same factor in the step-down unit at issue. The higher ratios in the recognized special care units show that the patients in the unit under consideration require a lesser level of specialized care than the patients in the recognized special care units. The unit provides a lesser level of nursing care than provided in the established special care units because the patients do not require the extraordinary care that patients in units such as the ICU and CCU require. Patients are placed in the step-down unit when they are no longer in immediate life-threatening situations.

Another indication that the TCU cares for patients who require a lesser level of care than those in the established special care units is reflected in equipment of that unit as compared to that of established special care areas. For example, the TCU provides only 2 hard-wire and only 8 telemetry monitors, although it has 16 beds. In the Provider's CCU all patients are monitored with hardwire units.

Although the charges and equipment of the various units are not conclusive as to the level of care supplied, they are an indication that the actual costs to the hospital are less. It follows that costs are less because the services and care furnished to patients in the TCU are not as extensive as those furnished to patients in the traditional special care areas. Patients in the step-down unit, by the admission of the Provider's own witnesses, do not require the intensive care supplied in the recognized special care units.

The Board held that the comparison of these statistics is biased. While the TCU nursing hours were relatively comparable to those of the CCU, the CCU had lower utilization. The CCU had to maintain high staffing under JCAH requirements. The Board concluded that the CCU nursing hours and costs should be adjusted for comparison to the same utilization level as that of the TCU. The Deputy Administrator notes, however, that there was no evidence that the CCU staffing would have remained at the same level with increased utilization. The usual response in this context would be to increase staff in order to maintain the proper level of care.

In its decision the Board referred to the Administrator's decision in *Loyola University of Chicago,* PRRB Decision No. 81-D54 and favorably compared the nurse to patient ratio in the TCU to the units in *Loyola.* Since the ratio of 1:2 and at a minimum 1:3, was a sufficient level of care in that case, it seemed to follow that a 1:3 ratio in the Provider's TCU should be sufficient. In *Loyola,* nursing hours in the unit under appeal were as high as or higher than in the same hospital's established special care units: they remained constant in the units under appeal for 24 hours each day. In *Loyola,* the appealed units did not serve the ICU or CCU as step-down care units. In this case the Provider's TCU nurse-to-patient ratio declined on the night shift which does not reflect extraordinary care on a concentrated and continuous basis. Further, by written hospital policy, the TCU is specifically an intermediate care unit.

All of the evidence establishes that the unit at issue renders care which is of a substantially lower level than the care rendered in the recognized special care units. Two physicians who regularly utilize the Provider's facility testified that the TCU functions as a subintensive unit to both the ICU and CCU. The patients in the step-down

unit are convalescing and are farther removed from critical and immediate life-threatening conditions than are patients in the recognized special care units such as the ICU and CCU. Visiting hours of the step-down unit reflect this in that they are more liberal than those in the established special care units. The patients' conditions are improving when they are in these units so that they do not need the restrictions required in the recognized special care units.

The TCU is neither equal to, nor comparable to the Provider's recognized special care units and, as such, does not qualify as a special care unit under 42 CFR 405.452 (d)(10). Obviously, some patients are more ill than others, and some patients convalesce faster than others. Some patients in this unit could be ill enough to need the concentrated care of an intensive care unit. Other patients in this unit could need only the care associated with a general routine area. However, the typical patient treated in this unit was not ill enough to require treatment in an intensive care unit and, in fact, had often been transferred from that type of unit because his condition had improved. 42 CFR 405.452(d)(10) specifically provides for the exclusion of post-operative recovery rooms, post-anesthesia recovery rooms or maternity labor rooms. The concept of the Provider's unit is substantially similar to these types of rooms. As such, it is specifically excluded by 42 CFR 405.452(d)(10).

With regard to the examples indicated in Section 2202.7B of the Provider Reimbursement Manual (HIM-15), the Deputy Administrator notes that no factor listed there is conclusive. Although the number of nursing hours and the source of patients are very important criteria to consider in a determination of the intensity of care provided, these criteria alone are not the only basis for the determination. However, when considered along with information concerning the various admission and discharge policies,

the type of patients treated, and the treatment provided, the criteria in Section 2202.7B may corroborate the conclusions reached on the issue of the level of care provided.

Decisions regarding entitlement to provider reimbursement must rest upon the cost reports submitted. Providers are required to keep adequate records upon which to base Medicare payment. Due consideration has been given to the testimony presented. Reimbursement must be based on auditable records and not essentially on testimony at the hearing before the Board showing the contrary. Thus, the contemporaneous records concerning nurse/patient hours must furnish the basis for payment, rather than estimates based on imputed utilization rates.

The Deputy Administrator, after considering the entire record taken as a whole, finds that the TCU is a step-down unit to the Provider's established special care areas. The TCU does not render the care necessary to qualify it as a special care unit. Accordingly, the TCU does not qualify as a special care unit for Medicare reimbursement purposes.

FINDINGS OF FACT

1. The amount in controversy exceeds $10,000 for both the 1977 and 1978 cost reporting period.

2. The Provider is a 492-bed, short-term, acute-care, hospital.

3. The Provider operated a Transitional Care Unit (TCU) which it claimed as a special care unit on its FY 1977 and 1978 Medicare cost reports.

4. The Provider's TCU was a 16-bed unit, its Intensive Care Unit (ICU) was an 18-bed unit, and its Coronary Care Unit (CCU) was a 10-bed unit (Hearing Exhibit: "Computation of Staffing Pattern").

5. All patients in the CCU are monitored, but in the Provider's TCU only 10 of 16 patients can be monitored, and only 2 of those by hard-wire (Tr. 61).

6. The Provider's TCU utilized telemetry monitoring which is less restrictive than the "hard-wire" monitoring utilized by the Provider's CCU (Tr. 48, 61).

7. The Provider's TCU was not as extensively equipped as the Provider's ICU or CCU (Tr. 60-61).

8. Patients in the Provider's TCU did not need all the life-saving equipment on a continuous basis that CCU and ICU patients needed (Tr. 63, 60-61, 92-3, 149).

9. Many patients in the TCU are postoperative patients recovering from surgery (Deposition of Dr. Graves, p. 15).

10. Approximately 50% of the TCU patients were transferred to the TCU from the ICU and CCU after their conditions had improved (Tr. 147).

11. Ninety-two percent of the patients transferred from the Provider's TCU were sent to routine care areas while the ICU and CCU each discharged 30% of their patients to the TCU and 65% and 50% (respectively) to routine care areas (Intermediary's Position Paper (IPP) Exhibit III).

12. The registered nurses in the Provider's TCU received the same critical care training as nurses in the established special care units, the ICU and CCU (Tr. 43-4).

13. The total nursing care hours per patient day in the TCU averaged 9.21. The CCU averaged 11.89 hours, and the ICU averaged 16.71 hours (Intermediary's Post-Hearing Brief, Exhibit A).

14. The Provider's TCU had available additional "float" nurses from the Provider's established special care units (Tr. 44).

15. The nurse-to-patient ratios decreased from the day to evening shift in the TCU (Tr. 80-1).

16. Comparison of charges for additional nursing required in units other than the routine care units showed that charges in the TCU were less than half of charges in the ICU and CCU (Tr. 151).

17. Comparison of nursing hours per patient day, nursing costs per patient day, unit costs per patient day (before and after step-down allocation) among the TCU, ICU and CCU shows that the ratio in the TCU is consistently less than the ratio in the established special care units (IPP, p. 1).

18. Visiting hours in the TCU were more liberal than those in the ICU: they were 2 hours twice a day, while the ICU allowed only 10 minute visits several times a day (Tr. 28).

19. Patients in the Provider's TCU were allowed to have the use of telephones and televisions, while patients in the ICU and CCU were not (Provider's Position Paper (PPP) p. 12 and Provider's Supplemental Exhibits, Exh. 3, p. 5).

20. Smoking was not prohibited in the Provider's TCU, but smoking was prohibited in the ICU and CCU (Provider's Supplemental Exhibits, Exh. 3, p. 5).

21. Written hospital policy governing the Provider's TCU stated that the purpose of the unit was to serve patients found well enough to leave the ICU and CCU (Provider's Supplemental Exhibit 3, p. 6).

22. Hospital policy required that patients requiring mechanical ventilatory support, or who were suspected of having an acute myocardial infarction within the preceding 3 days were not to be admitted to the TCU, but were to be admitted to the ICU or CCU (Tr. 149).

23. During the December 31, 1977 and 1978 cost years at issue, the patients treated in the Provider's Transitional Care Unit (TCU) did not require such care as was considered special in the Provider's recognized special care units, the ICU and the CCU.

24. The Provider's TCU treated patients who required less intensive care than those in the Provider's recognized special care units, the ICU and CCU (Deposition of Dr. Flynn, p. 41: Deposition of Dr. Graves, p. 7, 15, 19, 21: Transcript of Oral Hearing (Tr.) 63, 67).

CONCLUSIONS OF LAW

1. Medicare recognizes only two levels of care for reimbursement purposes under 42 CFR 405.452: routine services and special care services.

2. The Provider's Transitional Care Unit rendered an intermediate level of care which is not a recognized separate level of care for Medicare reimbursement purposes under 42 CFR 405.452.

3. The Provider's Transitional Care Unit does not meet all the criteria to be considered an intensive care unit or other special care unit under 42 CFR 405.452(d)(10).

4. The patients in the Provider's Transitional Care Unit do not require the extraordinary care contemplated by 42 CFR 405.452(d)(10).

5. The patients in the Provider's Transitional Care Unit do not require extraordinary nursing care on a concentrated basis as required by 42 CFR 405.452(d)(10).

6. The patients in the Provider's Transitional Care Unit do not require extraordinary nursing care on a continuous basis as required under 42 CFR 405.452(d)(10).

7. Since the care required by the patients in the Transitional Care Unit is not equal to nor comparable to the care required in the Provider's established special care

units, this unit does not qualify as a special care unit under 42 CFR 405.452(d)(10).

8. The care required by patients in the Provider's Transitional Care Unit, while different from the care required in the routine area, is not the extraordinary, concentrated and continuous care necessary to qualify it as a special care unit under 42 CFR 405.452(d)(10).

DECISION

The decision of the Provider Reimbursement Review Board is reversed. The Provider's Transitional Care Unit does not qualify as a special care unit for reimbursement purposes.

This Constitutes the Final Administrative Decision of the Secretary of Health and Human Services

(s) Paul R. Willging, Ph.D.
Deputy Administrator
Health Care Financing Administration

Date: 2/4/1982

[LETTERHEAD OF DEPARTMENT OF HEALTH AND HUMAN SERVICES]

Carson P. Porter, Esquire
Law Offices
Reisz, Porter & Rosenbaum
1207 Citizens Plaza
Louisville, Kentucky 40202

Dear Mr. Porter:

Re: Norton-Children's Hospital, Inc., Louisville, Kentucky, Provider No. 18-0088, Case No. 80-119, F/Y/E—December 31, 1977 and 1978, Decision No. 82-D24

This letter is transmitting the Provider Reimbursement Review Board's decision on the Hearing held on April 16, 1981.

The Board's decision is that:

> The Provider's TCU qualifies as a special care unit in accordance with 405.452(d)(10). The Provider is sustained.

For information regarding the Provider's rights of appeal involving this decision, please see the enclosures.

The Board will be glad to furnish any further information you may wish regarding this matter.

Sincerely yours,

(s) Thomas M. Tierney
Chairman

Enclosures 3

ISSUE:

Whether or not the Provider's Transitional Care Unit qualifies as a special care unit pursuant to 42 CFR 405.452.(d)(10)?

SUMMARY OF FACTS:

Norton-Children's Hospitals, Inc., is a 492-bed, short-term, acute-care hospital. Medicare cost reports were filed with Blue Cross/Blue Shield of Kentucky, Inc., for the periods ending December 31, 1977, and 1978. Notices of Program Reimbursement were issued by the Intermediary for the cost-reporting periods in dispute on September 27, 1979, and October 3, 1980, respectively. The Provider has appealed the Intermediary's reimbursable cost determination to the Provider Reimbursement Review Board pursuant to 42 CFR 405.1835ff. The jurisdictional requirements in the aforesaid regulations have been met.

During the cost-reporting periods under appeal the Provider maintained a 16-bed Transitional Care Unit (TCU). In filing its cost report, the Provider treated the TCU as a special care unit. The Intermediary took exception to this treatment and combined the cost and statistics of the TCU with the routine care cost center.

The Provider asserts that its TCU meets all the applicable criteria for a special care unit as set forth in 42 CFR 405.452(d)(10) as described below:

1. The TCU is clearly located within Norton-Children's Hospital.
2. The care required in the TCU is extraordinary in that it requires unusual training and equipment. The training and skills of TCU nurses are significantly higher than those of routine area nurses. Furthermore, the TCU has much more specialized equipment than the routine areas of the hospital.

3. The care required in the TCU is heavily concentrated in nature. Lifesaving equipment is always available. Monitors permit the staff to render one-to-one supervision and care as required at all times, particularly when a medical emergency arises.
4. The care in the TCU is provided on a continuous basis. Round the clock medical supervision is provided to the patients in the TCU.
5. The TCU is separate from the general routine areas of Norton-Children's Hospital.
6. The TCU possesses specific written policies for its training, organization, management and operation.

Testimony by the Provider's Assistant Administrator/ Director of Nursing and two physicians who practice at Norton-Children's Hospital support the aforementioned conclusions concerning the care rendered in the TCU. The Provider asserts that the Intermediary's findings with respect to care being rendered in the TCU has not been viewed from a medical point of view but rather from a mathematical computation of per diem costs. Drawing a conclusion that the TCU does not render extraordinary care that is concentrated on continuous basis based on the Intermediary's mathematical computation is without substance. In the instant case, the per diem and nursing costs are distorted because of differing occupancy rates in the Provider's five special care units. The Provider points out that if the per diem cost and nursing cost for the special care units were recast using an occupancy level of 90 percent for the 5 special care units the per diem and nursing costs would be arrayed in the following order:

	Per Diem Cost	Nursing Costs Per Day
Burn Unit	$201.02	$74.73
ICU	186.35	82.29
TCU	115.41	48.07
Neonatal	114.66	46.28
CCU	112.28	40.05

Thus, in comparing the TCU to the other special care units, two important conclusions can be drawn:

1. In each category, the costs per day in the TCU exceed the costs per day in both the CCU and Neonatal Unit. Both of these units are recognized by the Intermediary as special care units; and
2. The TCU costs per day are much greater than those incurred in the General Routine area of the hospital. (Routine per diem costs—$94.61, Nursing Per Diem Costs in Routine area—$22.25.)

Finally, the Provider argues that the Board should not give credence to HIM-15, Section 2202.7, in rendering its decision in the instant case. In *John Muir Hospital, Inc.* v. *Harris,* N.D. CA., 1980, the court held that Section 2202.7 should not be applied because it "was not enacted pursuant to the rulemaking requirements of the Administrative Procedure Act and did not exist at the time the Definitive Care Unit was planned, constructed, and initially operated." HIM-15, Section 2202.7 was promulgated in June, 1975. Norton-Children's TCU was established in 1971. Thus, the Intermediary should not be permitted to retroactively apply Section 2202.7.

The Intermediary asserts that under 42 CFR 405.452 (b)(1)(i) and 405.452(e)(2)(ii) only two levels of care are recognized, that is, special care units and routine care. In order to qualify as a special care unit, 42 CFR 405.452(d)(10) requires that the unit be "one in which the care re-

quired is extraordinary and on a concentrated and continuous basis." While "extraordinary, concentrated and continuous" are not defined in the Regulation, HIM-15, Section 2202.7 provides guidance for construing these terms. In applying the guidance of HIM-15, Section 2202.7, the Intermediary asserts that the TCU does not qualify as a special care unit. This conclusion has been reached because:

1. The TCU's cost per patient day, nursing costs and nursing hours were significantly below the Provider's ICU;
2. The transfer patterns for patients in the TCU indicated a high percentage of patients coming from the ICU and CCU; and,
3. Certain special life-saving equipment was not routinely available in the TCU.

Accordingly, the Intermediary finds that the Provider's TCU does not qualify as a special care unit.

CITATION OF APPLICABLE LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

I. Regulations—42 CFR 405, Regulations No. 5, Subpart D

Section 42 CFR 405.452(d)(10)—Intensive Care Type Inpatient Hospital Unit

II. Program Instructions—HIM-15-1

Section 2202.7 — Special Care Units/Intensive Care Type Units

CONCLUSIONS AND FINDINGS

The Provider Reimbursement Review Board, after consideration of the facts, the parties' contentions and evidence

presented, concludes and finds that the Provider's TCU qualifies as a special care unit. In the instant case, the Intermediary's prime reason for not accepting the TCU as a special care unit is predicated on mathematical assertions, that is, cost per patient day, nursing costs per day and nursing hours per patient day. However, as demonstrated by the Provider, the mathematical assertions of the Intermediary are biased because of a failure of the Intermediary to reconcile the varying occupancy levels of the Provider's special care units. Even if the Intermediary's statistics can be considered reflective of care being extraordinary, concentrated and on a continuous basis, the nursing hours per patient day in TCU (9.21) substantially exceeds those of the routine care areas (5.34). Accordingly, the nursing hours ratio is better than 1 to 3 ratio. In a similar case involving special care units, the Administrator stated:

> "Considering the level of nursing care, for example. it is significant that nurse-to-patient ratio in the four units (i.e., special care units) at issue was generally 1:2 and at a minimum 1:3." *Loyola University of Chicago* PRRB Decision 81-D54."

Accordingly, the parameters used by the Administrator in *Loyola University* should be equally applicable to this case.

In addition, the Provider has presented competent testimony indicating the existence or availability of special life-saving equipment that was utilized in the TCU. Further, the special training given the TCU enabled the nurse to perform many life-saving services which could not be performed by a nurse in the routine care area. In fact, the TCU nurse receives the same training as the ICU and CCU nurse. The TCU, ICU, and CCU nurse are interchangeable.

Thus, the TCU meets both an objective and subjective test in qualifying as a special care unit.

DECISION

The Provider's TCU qualifies as a special care unit in accordance with 405.452(d)(10). The Provider is sustained.

Board Members Participating

Thomas M. Tierney
James Houdek, Jr., CPA
Bette A. Kraus

FOR THE BOARD

December 10, 1981

(s) Thomas M. Tierney
Thomas M. Tierney
Chairman

42 U.S.C. 1395x

(v) Reasonable Cost

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, and may provide for the use of charges or a percentage of charges where this method

reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

42 U.S.C. §1395hh. Regulations

The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

42 C.F.R. §405.425(d)(10) (1972)

Intensive care units, coronary care units, and other special care inpatient hospital units.

To be considered an intensive care unit, coronary care unit, or other special care inpatient unit, the unit must be in a hospital, must be one in which the care required is extraordinary and on a concentrated and continuous basis and must be physically identifiable as separate from the general patient areas. There shall be specific written policies for each of such designated units which include, but are not limited to burn, coronary care, pulmonary care, trauma, and intensive care units but exclude post operative recovery rooms, post-anesthesia recovery rooms, or maternity labor rooms.

42 C.F.R. §405.452 (1980)

(d) *Criteria for identifying intensive care type units.* For purposes of determining costs under this section, a unit will be identified as an intensive care type inpatient hospital unit only if the unit--

(1) Is in a hospital;

(2) Is physically and identifiably separate from general routine patient care areas, including subintensive or intermediate care units, and ancillary service areas. There cannot be a concurrent sharing of nursing staff between an intensive care type unit and units or areas furnishing different levels or types of care. However, two or more intensive care type units that concurrently share nursing staff can be reimbursed as one combined intensive care type unit if all other criteria are met. Float nurses (nurses who work in different units on an as-needed basis) can be utilized in the intensive care type unit. If a float nurse works in two different units during the same eight hour shift, then the costs must be allocated to the appropriate units depending upon the time spent in those units. The hospital must maintain adequate records to support the allocation. If such records are not available, then the costs must be allocated to the general routine services cost areas;

(3) Has specific written policies that include criteria for admission to, and discharge from, the unit;

(4) Has registered nursing care available on a continuous 24-hour basis with at least one registered nurse present in the unit at all times;

(5) Maintains a minimum nurse-patient ratio of one nurse to two patients per patient day. Included in the calculation of this nurse-patient ratio are regis-

tered nurses, licensed vocational nurses, licensed practical nurses, and nursing assistants who provide patient care. Not included are general support personnel such as ward clerks, custodians, and housekeeping personnel; and

(6) Is equipped, or has available for immediate use, life-saving equipment necessary to treat the critically ill patients for which it is designed. This equipment may include, but is not limited to, respiratory and cardiac monitoring equipment, respirators, cardiac defibrillators, and wall or canister oxygen and compressed air.

Special Care Units (Provider Reimbursement Manual, Part 1, §2202.7) (1972)

To be considered a special care inpatient hospital unit, the unit must be in a hospital, must be one in which the care rendered is extraordinary and on a concentrated and continuous basis and must be physically identifiable as separate from general care areas. There shall be specific written policies for each of such designated units which include, but are not limited to, burn, coronary care, pulmonary care, trauma, and intensive care units, but exclude postoperative recovery rooms, postanesthesia recovery rooms or maternity labor rooms. Segregation of patients to specific areas by type of illness or age, such as psychiatric, neuro-psychiatric, geriatric, pediatric, mental health, rehabilitation, etc., does not qualify as special care inpatient hospital units for purposes of apportionment, unless the above requirements are met.

Special Care Units (Provider Reimbursement Manual, Part 1, §2202.7) (1977)

A. Requirements to Qualify as an SCU. — To be considered a special care hospital unit, the following requirements must be met:

1. The unit must be in a hospital.

2. The unit must be one in which the nursing care required is extraordinary and on a concentrated and continuous basis. Extraordinary care incorporates extensive life-saving nursing services of the type generally associated with nursing services provided in burn, coronary care, pulmonary care, trauma and intensive care units. For this reason, special life-saving equipment should be routinely available in the unit.

3. The unit must be physically identifiable as separate from general care areas and the unit's nursing personnel must not be integrated with the general care nursing personnel.

4. There shall be specific written policies for each of such designated units which include, but are not limited to, burn, coronary care, pulmonary care, trauma, and intensive care units, but exclude postoperative recovery rooms or maternity labor rooms. The unit's staff must be specially trained to serve in such areas. Segregation of patients to specific areas by type of illness or age, such as psychiatric, neuropsychiatric, geriatric, pediatric, mental health, rehabilitation, etc., does not qualify as special care inpatient hospital units for purposes of apportionment unless the above requirements are met.

* * *

B. Subintensive Units. — Some hospitals have units which provide more intensive care than that provided in the general care areas yet not sufficiently intensive to per-

mit the unit to meet the requirements to qualify as a special care unit under the definition provided in paragraph A above. These units are typically designated as subintensive, subacute, progressive, or intermediate care units, etc. Such subintensive units are not special care units for purposes of Medicare reimbursement.

There may, however, be cases where a unit is not easily identified as a subintensive or special care unit without further study. In such cases, a review of the written policies of the various units will indicate whether a unit is or is not providing care as defined in paragraph A. If the intermediary determines that such a unit meets the requirements of paragraph A above, then the unit will qualify as a special care unit.

For example, one indication of whether the unit in question meets the requirements specified in §2202.7A.2. is the extent of nursing services provided in the unit. If the hours of nursing service per patient day are less than the hours of nursing services provided in an established special care unit, such as an ICU or CCU in that hospital or in other area hospitals if the hospital has no established special care unit, then the unit in question would generally not qualify as a special care unit. Hospitals should maintain such records as are needed to establish the nursing time in such units. . . .

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health Care Financing Administration
[42 CFR Part 405]

Medicare Program; Definition of Hospital Special Care Units for Reimbursement Purposes

AGENCY: Health Care Financing Administration (HCFA), HEW.

ACTION: Proposed rule.

SUMMARY:

This rule refines the definition of hospital special care units and clarifies the requirements for their reimbursement under the Medicare program. The present special care unit reimbursement regulation has been erroneously interpreted by some hospitals to apply to units that furnish a level of care that is less than that furnished in intensive care.

Under the present regulation, units have been designated as special care units, when they are, in fact, intermediate or subintensive care units that render a less intensive level of care. The purpose of this amendment is to clarify the intent of the regulation that the term "special care unit" applies only to those units rendering a level of care that is comparable to intensive care.

DATES:

Consideration will be given to written comments or suggestions received on or before July 16, 1979.

ADDRESSES:

Address comments to: Administrator, Health Care Financing Administration, Department of Health, Education and Welfare, P.O. Box 2372, Washington, D.C. 20013. When commenting, please refer to MAB-84-P. Agencies and organizations are requested to submit their comments in duplicate. The Health Care Financing Administration specifically requests comments and supporting data, if possible, on §405.412(d)(10)(v) and (vi) of the proposed regulation. Comments will be available for public inspection, beginning approximately 2 weeks after publication, in room 5231 of the Department's offices at 330 C Street, S.W., Washington, D.C. on Monday through Friday of each week from 8:30 to 5 p.m. (telephone 202-245-0950).

FOR FURTHER INFORMATION CONTACT:

William Goeller, Medicare Bureau, Health Care Financing Administration, Room 405 East High Rise Building, Baltimore, Maryland, 21235, (301) 594-9820.

SUPPLEMENTARY INFORMATION:

Section 1881 (v) of the Social Security Act provides that the Secretary may establish, by regulations, the methods to be used in determining the reasonable costs of services furnished to Medicare beneficiaries. The methods used in reimbursing providers are based on costs actually incurred in furnishing services to beneficiaries. The regulations recognize that different types of care may result in different per-diem costs. The per-diem cost of intensive care and other special care units will usually exceed the per-diem cost of general routine care. This is because intensive care units require greater staffing and more specialized equipment than what is required in the general routine areas. Thus, the present regulations allow for a

separate computation to determine Medicare's share of intensive care and other special care unit costs as well as its share of general routine care costs.

Recently, some hospitals have designated as special care units, units that provide various levels of care. These units provide a level of care which is less than provided in intensive care and more than furnished in the general routine areas of the hospitals. The cost of operating these units falls somewhere between those of operating intensive care units and the cost of furnishing general routine care. These units, sometimes referred to as intermediate or subintensive care units, are frequently cited as a way to reduce hospital costs. When they are used as step-down units from intensive care or to avoid the intensive care unit altogether, hospital costs are reduced. Yet, if the hospitals receive reimbursement for these units as special care units, Medicare reimbursement will be inequitably increased. Notwithstanding that many of the intermediate or subintensive care units provide a level of care which is less than intensive care, some hospitals contend that the units should be designated and reimbursed as special care units under the current regulation.

Since the adoption of the special care unit reimbursement policy, we have maintained that only those units rendering a level of care comparable to intensive care should be reimbursed as special care units. We maintain that a subintensive level of care is only a part of the spectrum of general routine care. Although a subintensive care unit may not fit the regulatory description of a special care unit, we will reimburse for the care rendered in that unit by combining the reasonable costs of care in that unit with the reasonable costs of care in other general routine areas. Any reimbursement for general routine service costs, however, will include an inpatient routine nursing salary cost differential, and be subject to the schedule of limits on hospital inpatient general routine service costs.

Several recent Provider Reimbursement Review Board and Federal court decisions have addressed the issue of whether intermediate or subintensive care units are special care units and have come to varying conclusions. These decisions show an existing lack of uniformity as to what constitutes a special care unit. In addition, since the regulation was issued, substantial changes have occurred in hospital organization, administration, and financial practices. Increasingly, the inpatient hospital special care unit concept has become an acceptable part of medical care practice. We perceive a definite need to further refine and clear away ambiguity as to what a special care unit is for Medicare reimbursement purposes. Thus, we propose to amend the regulation.

The amendment would clarify the regulation by providing seven specific criteria which a unit must meet to qualify as a special care unit. One such criterion is that there must be a minimum of 12 scheduled hours of direct patient nursing care per patient day. This 12 hour figure is based on data contained in the American Hospital Association's periodic publication of Hospital Administrative Services data for the period ending December 31, 1977. This information indicates that the great majority of hospitals have at least 12 hours of such care per patient day in their intensive care units.

Another criterion is that a minimum of 6 hours of direct patient care per patient day must be furnished by registered nurses and cannot be furnished by aides or orderlies. As a result of a sample of rural and urban hospitals, we concluded that at least 6 hours of direct patient-care is normally furnished by registered nurses in intensive care type units. This criterion takes into consideration that the level of required registered nursing care in special care units is considerably higher than the level that is required in general routine areas. In most cases, only regis-

tered nurses possess the necessary expertise for furnishing care to patients in special care units. In no case would aides or orderlies satisfy the requirement.

The other criteria specify that the unit must be in a hospital, must be physically and identifiably separate from other areas and units in the hospital and must have specific written policies concerning admission, discharge and other matters. In addition, the unit must be permanently equipped with life-saving equipment to treat the critically ill patients for whom it is designed, and registered nursing care must be furnished daily on a continuous 24-hour basis. We invite comments on whether the admission and discharge policies for special care units must be consistent with the standards set by the PSRO's and must be approved in advance by PSRO's. (Proposed regulations on PSRO hospital review were published in the Federal Register on January 25, 1977 and final regulations will be published soon.)